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CHILD WELFARE is a forum for discussion in print of child welfare problems and the programs and skills needed to solve them. Endorsement does not necessarily go with the printing of opinions expressed over a signature.

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PSYCHIATRIC CONSULTATION IN SOCIAL AGENCIES*

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Two traditional functions of a psychiatrist in a social agency, consultation with staff members about specific clients and teaching general or specific subjects related to psychiatric concepts, are discussed in this paper.

An agency seeking a consultant's help for the first time always wants help with case problems. The immediacy of a difficult problem always supersedes teaching sessions without objections from anyone.

The object in focusing on the emotional problems presented by a client is to facilitate diagnosis, a casework or therapy plan, and its execution. The consultant is rarely allowed more than one brief hearing of any particular case, because of pressure of cases, and it is generally inappropriate or outside reason for him to attempt more than an understanding of the dynamic forces operating in the client's personality and living as it is presented at that moment. Inevitably the most useful finding in consultation is a clear delineation of the client's potentialities for constructive change. The assessment of a client's adaptive potential necessitates careful formulation of genetic and current factors in his life. Interpersonal relationships, psychosexual makeup, and the degree of equilibrium in his living are all parts of the consultation proper.

Antisocially acting-out adolescents, such as unmarried mothers, or delinquent boys, are regular clients of child welfare agencies. These difficult cases stir up anxiety in the worker or may provide a kind of defensive callousness, so that the worker's reaction to clients becomes an issue in the consultation. This offers a pitfall for the consultant too, because undue attention to the worker's personality may well provoke more anxiety in the caseworker and make him less effective.

Another potential trouble spot exists in the case presentation. The consultant may tend to get too active, taking over the clinical management of the case and the supervisor's function as well. This is often fostered by the agency staff. Planning and decisions are agency staff functions. Adoption studies offer a clear-cut example, since they involve an individual worker's appraisal, a staff committee review, a consultation, if indicated, and a staff decision based on all these.

For the most part, a consultant becomes acquainted with the problem cases, the failures, the ones that catalyse the worker's anxiety. Yet this limit helps, because it enables the consultant to see where the quantity of emotional energy is expended by a given worker or agency. This is a far more useful service than a set of statistics in an annual report to the county agent or the state office might indicate. The existence of one really tough situation can upset a worker's whole case load for awhile, especially if there is no consultive help available.

Teaching Sessions

The advantage to the agency of the stimulation of seminars needs no emphasis. The teaching may be in the form of seminars or direct presentation by the analyst, depending on staff interests and needs. The common topics are normal and pathological psychology, personality development, and principles of diagnosis and therapeutic technique. The question of just what constitutes casework as differentiated from other forms of psychotherapy is always a welcome topic, and a knotty one, too. Sessions may be used to stimulate interest in basic conceptions, for instance, in social trends, or in the classic literature of the field.

The secondary and occasional functions of the consultant are numerous, and some are

*Given at CWLA Southern Regional Conference, Nashville, Tenn., May 1957.

controversial. Some involve exploitation of the consultant's prestige as an M.D., or even legitimate use of his medical background. He can, for instance, furnish medical information on the somatic illnesses or complaints of clients when these are issues in casework. The consultant with reliable information on medical resources can often indicate the physicians who are suited to work with emotionally disturbed patients.

He may be able to expedite emergency hospitalization of disturbed psychotics perhaps through personal connections. This may be an extracurricular service, but one which is greatly appreciated by the worker who might otherwise spend the night holding the fort with a terrified schizophrenic. Occasionally, it is appropriate for the consultant to be used as a clinician, to make a direct examination of a client, even though he ceases to be purely a consultant in so doing. In small agencies in smaller communities, the mere existence of consultant service lends prestige to the agency's work. The authority of Dr. So-and-So can be invoked in a number of ways, for instance with country doctors, or a youth court judge. When the worker says that Dr. So-and-So, the psychiatrist, was of the opinion that further efforts at noninstitutional rehabilitation of a patient would be futile, the desired commitment papers are apt to come through more readily.

Legal aspects of clients' problems, or of agency policy and functions, are always coming up. While as a rule the consultant must be inducted into these mysteries, in discussion of such matters, there is often opportunity to speculate on shifting cultural attitudes, or on the possible usefulness of changing social statutes. In at least one Southern state, for example, ADC is restricted by law if the mother is unmarried and continues to have illegitimate children or to live in an illicit relationship with a man. The rationale of such laws is that the state will be free of the responsibility of financing much of the upbringing of the children of common-law marriages. But is it a good law? Does it hurt some children's chances for healthy development?

A final group of consultant functions relates to workers' personalities. When asked by an agency head, the consultant is within bounds in furnishing opinions about such matters. Except in extreme instances, however, he has no business offering this sort of information unsolicited. This sort of consultant activity is found only in established, useful agency-consultant relationships which have durable qualities of cooperativeness. Supervisors may request the consultant's help with problems in work with other staff members. Sometimes, agency-consultant friction may be reviewed with the executive and supervisors.

Selecting Cases for Consultation

Selection of cases for consultation is worth careful thought. The overt motive for consultation is to clarify issues. However, undercover motives, of which the worker may be more or less unaware, often liven the sessions. Cases can be selected to "test" the consultant, for instance, or to demonstrate the futility of expecting any good to come of casework or of consultation. A worker may have a need to maneuver the consultant into supporting an opinion with which the supervisor disagrees. If the anxiety involved is disruptive to the avowed aim of consultation, it should quickly be brought into the open.

"Typical problem" cases are good for large group discussions, as they lend to generalization. Countertransference problems are best limited to consultant and caseworker, usually with the supervisor in attendance.

The group consultation situation is apt to have a distinct atmosphere. Generally, it is friendly, trusting, and constructive, but sometimes it is not, even after time should have allowed for the solution of the initial problems of establishing a working relationship.

In a typical new consultant-agency situation, an initial period of anxiety on both sides is followed by a mutual testing phase, ending in an effective working relationship. The time required for the achievement of this happy ending is tremendously variable. The requirements of private agencies that have had

a number of previous consultants, involved in training student workers, are the most difficult to deal with from the consultant's point of view. This could be because the agency is sensitive, or because the consultant feels he must live up to the standards of some previous consultant. Also, such an agency is more apt to be preoccupied with minutiae of theory than a hard-pressed public agency. On the other hand, it is likely to be the aggressive and over-confident young psychiatrist, perhaps still in his analytic training, who manages to antagonize the workers.

In some unfortunate situations, the process lingers on interminably, and ends only in frustrating disintegration and more or less open antagonism. It should go without saying that the individual personalities involved are all-important, and the least subject to accurate prediction by an agency choosing a consultant, although there are some helpful rules to follow.

Requirements for Consultant

A consultant should be well-trained in dynamic psychoanalytic therapy. In child welfare agencies, or in almost any agency, he should have had special training and experience in work with children. The workers who first approach a prospective consultant should review their respective ideas about his role and the help they need. He can find out what is wanted of him, how the agency expects to use him, etc. It is not his prerogative as a consultant to determine how his appraisal of a client is going to be used. He should meet with the workers in the agency office, if possible, especially for group consultations. This lends emphasis to the concept of consultation being an integral part of the agency. He should be paid an adequate fee. He has only his time to sell to make a living. The fee for this sort of work varies from locality to locality, but ideally is always somewhat higher than the usual private therapy fee. The analyst should be familiar with the ways of social workers, and sympathetic to their function. Previous experience as a consultant is not essential, and throughout the South at least, experienced consultants are actually rather rare.

Although an agency might inadvertently hire a hostile, incompetent, or otherwise unsatisfactory consultant, he can always be fired. The situation is different when the consultant, here assumed to be a good one, finds his services sought by an agency staffed by a number of workers whose attitude is, "just prove you can offer us something." A training agency seems to permit more of this than do other agencies, but it is possible in any agency where supervisor-worker relationships are strained. To be sure, the consultant may make his most effective contribution to the agency in resolving such tense conflicts but it is best not to expect too much of him in the way of understanding case studies so long as this situation exists.

A consultant cannot be effective without finding this activity rewarding and interesting. In addition to the satisfaction of broadening their own vistas, most analysts who engage in consultative work with agencies derive improved techniques and flexibility from the association. As for social agencies, it appears that regularly scheduled psychiatric consultation is more and more regarded as truly essential to proper function.

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PSYCHIATRIC CONSULTATION—THE AGENCY VIEWPOINT*

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The uses, values, and limitations of psychiatric consultation to child welfare agencies and the conditions under which it can be most effective are thoroughly explored in this article.

Two important values of consultation to the social agency are: enhanced casework treatment, and in-service training, which should be focused toward increasing the social worker's understanding of individual dynamics.

Through consultation social workers can increase their diagnostic understanding and capacity to formulate treatment plans. The psychiatrist offers a broadened knowledge of intra-family dynamics and can assist in interpreting cultural factors as they affect individual behavior. As a result the setting of goals in casework treatment and in termination of cases is bettered. In this way consultation can help the agency to determine how much direct service it can offer certain children, and to clarify the overall aims of its program.

A psychiatric consultant on a social agency staff lends a certain authority to the agency's decisions. When a social worker says, "I have discussed this with our psychiatrist," his opinions and suggestions carry a greater weight with other professionals and with individuals in the community. Whether social workers should consciously take advantage of this practice, or whether it should be used at all, is debatable. It is still a reality in our contacts with people.

All the advantages of consultation do not accrue to the agency. The psychiatrist may gain from the breadth of experience provided by association with workers in intimate contact with community problems. He may learn more about social situations surrounding a given problem than it is possible to learn in his own office; he may find an interesting and stimulating relief from the confines of his own patient load; he may greatly refine his teaching and consultation skills; and he is afforded an excellent opportunity to learn communication with other disciplines.

Before employing a psychiatrist, a social agency must consider whether it is actually ready to undertake consultation. One factor in readiness is solid identification with casework; otherwise, there may be the tendency to over-identify with psychiatry and to attempt a watered-down version of psychotherapy or psychoanalysis with the accompanying disappointments to both patient and social worker. It is one thing to utilize the superior knowledge of dynamics that the psychiatric consultant can offer, and another to attempt using psychiatry's methods and techniques without full training and proper supervision.

It is my feeling that social workers in a social agency should practice casework therapy; however, this viewpoint is not universally shared, as some psychiatric consultants are teaching psychotherapy techniques to social workers. They believe that social workers can and should do psychotherapy under psychiatric supervision or consultation. It appears sounder for social workers to maintain their casework approach, utilizing other psychotherapeutic techniques when they are adequately taught and supervised. Should they become involved in such highly developed therapeutic techniques as interpretation of unconscious material or analysis of transference it is the psychiatric consultant's responsibility to help them refocus their work.

The agency should be well organized administratively so that its purposes, procedures, lines of authority and program can be readily understood by both consultant and staff. If the staff is not clear about who

* Given at CWLA Southern Regional Conference, Nashville, Tenn., May 1957.

carries the responsibility within the agency, the psychiatrist may take over some of the administrative responsibility, either out of the agency's urging him in that direction or his own need to move in where strength is obviously lacking. Administrative direction shared by psychiatrist and social worker in guidance centers and certain other clinic settings has proven feasible and workable, but a social agency should have its own administrative head if it is to function smoothly and efficiently.

The agency must have a staff sufficiently trained to do adequate case studies, to record pertinent material, and to do casework therapy. If its workers do not possess this basic understanding and training, they may need more time with trained supervisors or with a social work consultant skilled in casework techniques. The psychiatrist must not take the place of a supervisor, nor become involved in casework techniques, nor undertake basic social work training of an agency's personnel.

The agency should be stable in terms of administration, program and staff. The degree of stability may determine the type of psychiatric consultant one should try to get —whether he should be highly skilled in case consultation only, or in program planning and agency administration.

Selection of a Psychiatrist

In selecting a psychiatrist, the agency should give thought to more than its need for a consultant and the availability of a psychiatrist. After all, a social agency can survive without consultation. However, if an agency decides to use this resource, it should have in mind specific gains it wishes to derive from the experience.

The actual selection should be done by the agency executive. He may want his staff's suggestions and may delegate certain tasks that must be worked out with the psychiatrist, but the decision of who is employed should never be left to a staff member.

The social agency should carefully look into the training and experience of the psychiatrist under consideration. The GAP Committee on Psychiatry and Social Work states that:

"As a specialist, (a consultant psychiatrist) he should have completed the requirements for certification by the Board of Neurology and Psychiatry. Training and experience in child psychiatry is desirable. He should have a clear understanding of the concepts of dynamic psychiatry. . . . He has to transmit his knowledge of dynamic forces rather than his techniques of treatment. The consultant should not only understand the dynamics of human behavior but he should be able to communicate this knowledge to members of other disciplines in understandable terms. He needs to be alert to the existence of and effect upon the individual of the sub-cultures of which the client may be a member. He should recognize the part the family and society plays in defining the function of a social agency. His training should enable him to evaluate his professional relationship with staff members and to recognize his own skills and limitations as well as those of the individual staff members."[1]

Social workers are often reluctant to look into a psychiatrist's background, but this can hardly be justified when one is selecting a professional who will exercise considerable influence over his staff's decisions and growth. The agency and the psychiatrist may exchange references so that both can secure objective evaluations of the other's qualifications. The agency may then talk with the head of any training group to which the psychiatrist belongs, the chief of psychiatry at the medical school in the area, and other agencies that have used him as consultant.

The psychiatrist should also possess the interests and personality traits that make a good consultant. If he has little regard for social work and its practice, he will have difficulty identifying with the agency and its program, and it is doubtful that he can be of help. He must not have the attitude that his primary job is to teach the social worker; rather he should look upon consultation, especially during its early stages, as a mutual learning experience.

Dr. Anne Benjamin points out that the consultant should be experienced in therapy with adults and children, if possible. He

[1] "The Consultant Psychiatrist in a Family Service Agency," Group for the Advancement of Psychiatry Report No. 34, March 1936.

must be a clinician as well as a diagnostician. It is preferable that he be trained in consultation techniques, though such training is rare.[2]

Orienting the Psychiatrist

The psychiatrist should know the agency executive first and through him become familiar with its philosophy, policies and procedures. The staff and the psychiatrist should understand clearly what the consultant's role is—whether he is to consult on cases, give seminars, see occasional patients, or any combination of these roles. In this way the various roles will not become so complicated.

The get-acquainted period between psychiatrist and the caseworkers need not be an elaborate process involving several consultation sessions. Launching into an individual case early in their contacts may serve to accelerate their acquaintance. When staff and consultant can begin to learn about each other through discussion of case material, it may structure the conferences sufficiently to reduce the anxiety natural to a new experience.

Should an agency have more than one psychiatric consultant it is best to designate one as senior consultant and to let him help orient incoming consultants. Older consultants should by all means meet new ones when they first come on the staff.

Deciding the time to be given is a twofold problem involving how much the agency needs and can pay for and how much time the psychiatrist has available. Ideally, an agency would secure at least one two-hour conference each week; however, a number of agencies have profited from one session each two weeks. Still others feel there is value in psychiatric consultation given two or three times a year. No matter how few the consultation sessions, if they help the staff they are worthwhile.

Two-hour conferences are not arbitrarily selected. They have often proved ideal in length. One hour is generally not sufficient time to enter fully into cases and more than two hours may tire both staff and consultant. It is better if one, or a few consultants, give a block of time than if several each give a little time.

The question often arises as to whether the agency staff should go to the psychiatrist's office or he to the agency. It appears advantageous for the sessions to be held at the agency office, so that the psychiatrist may better acquaint himself with the total staff and the agency set-up. The staff is likely to be more relaxed in their own quarters, particularly during the early stages, and there may be certain mechanical advantages such as ready access to records, secretarial help. The plan should not be inflexible. It may be more convenient, for reasons such as travel time, to hold conferences at the psychiatrist's office. Some agencies alternate between their office and the consultant's. This should be handled according to mutual convenience.

Who attends consultative sessions will largely determine the focus of consultation. When the emphasis is on problems of a specific case the caseworker, his supervisor and perhaps the director of social work should participate. Often an agency may require its entire social work staff to attend as a part of in-service training. In the larger group, there is likely to be more generalizing with a view toward everyone benefiting from the consultation. There are inherent dangers in this, as workers may apply generalizations inappropriately.

Total staff participation may cause concern on the part of the individual worker presenting material. A regular practice of staff conferences in which all personnel participate will insure that this isn't a completely new experience.

There is no reason to defer to any social worker who may have reluctance in presenting a case for consultation, except possibly the new worker who hasn't yet become fully acquainted with the agency. Each staff member should take his turn in presenting a case and no worker who feels ill-at-ease in presenting material should be coddled. Any-

[2] Discussion by Dr. Anne Benjamin at Louisiana State University, Institute on "Psychiatric Consultation to Social Workers" March 25, 1957, Baton Rouge.

one who has undergone social work training and proposes to help people with their problems should be able to master the art of sharing material and ideas and revealing feelings, understanding and skills. If he cannot, he will not be able to use consultation.

Naturally, there will be exceptions in the presentation of cases, such as the case in which the worker's relationship to the client is so upsetting he cannot discuss it freely. In these instances opportunity should be given the caseworker to see the psychiatrist alone, without supervision.

When Consultation Should be Used

Most often consultation is asked

(1) when the agency does not fully understand the dynamics of a case,
(2) when they do not understand the effect of the patient's problem on other members of the family,
(3) when they do not know whether casework therapy is indicated,
(4) when emergency situations arise that may mean immediate psychiatric referral, and
(5) when there are problems in the worker-client relationship.

Consultation can advantageously be used, in some cases, after the intake interview to determine which ones the agency can handle and which should be referred for psychiatric study. Other cases may be presented after more complete study, when more information is available.

It is important that the staff know why a particular case is selected for consultation, whether for one of the above reasons or for teaching purposes. Unless there are specific questions to be dealt with, considerable staff and consultant time may be wasted.

Cases are presented for consultation in two principal ways: either the psychiatrist reads the case record or a prepared summary ahead of time, or the worker presents it orally. More often the two are combined with written material available to the consultant ahead of time and further material presented orally by the worker at the conference.

Obviously, the reading of entire case records has its disadvantages, as some are quite lengthy, detailed and repetitive. Considerable time may be wasted, and the consultant may lose sight of important factors in the case. Unless the psychiatrist's office is so near the agency that he can drop in to read records there may be an added problem of sending confidential records out of the agency.

Summaries prepared by the social worker have several advantages in aiding to crystalize his thinking, focusing on pertinent factors and pointing up the problem areas. Also, it is likely to be better preparation for the consultation session. The summary offers the psychiatrist a look at the important information in brief form. Should the consultant travel any distance, particularly by train or plane, he may study the summary on the way to the agency. To prevent identification of a record by an over-the-shoulder reader, only first names and initials should be used in summaries.

Unless there is a definite plan as to what should go into the summary it may wind up as a small case record without the necessary focus on pertinent information. A number of agencies use the following, with some variations:

A. Identifying information—name, age, family make-up, economic status
B. Source and reason for referral
C. Reason client gives for asking help
D. Description of client
E. Past history and present problems
F. Relationship with worker and course it has taken
G. Caseworker's evaluation of problem
H. Course that casework therapy has taken

Although a written summary is an excellent aid in consultation, the decision to use it or not should be based on whether the psychiatrist and the social worker find it helpful.

Oral presentation of material puts the responsibility on the social workers. They must still summarize in order to bring out only the important factors. It reflects the worker's feelings and reactions to the patient better than a summary.

The combined use of summary and oral presentation is undoubtedly preferable as it gives advantages of both and provides a better focus. It is likely to lead to healthy discussion which is a primary objective of

consultation. Who begins the discussion is not so important as the free exchange of ideas between staff and consultant.

Techniques in Consultation

The psychiatrist should read the case summary, listen to the caseworker, and together they should formulate the dynamics of the case as well as the objectives and limitations of treatment. Herein lies one of the real problems of consultation. Social workers often await the psychiatrist's explanation of the case, and he may fall into the trap of doing too much. Should he need to show off his superior knowledge or feel his job is to teach social workers, these attitudes may exhibit themselves at this point.

Sometimes the psychiatrist may need to talk even when social workers do not wish an explanation. Social agency staffs sometimes complain that the psychiatrist doesn't listen enough but begins to discuss the case before the caseworker has presented the material and his own point of view. The psychiatrist may generalize too readily, causing the caseworker to lose focus on the problems at hand. More learning takes place when there is a sharp focus on the problem in a case, on understanding what is involved in these problems and on evaluating possible solutions. Generalizations should take place only when some aspect of the case particularly lends itself to application on a broad basis and when the staff actually wishes the consultant to generalize. Most social workers will raise questions that lead to generalizations, and this is a better time for the consultant to offer them.

As consultation progresses the psychiatrist must become acutely aware of his consultees' level of understanding. The new, inexperienced worker might feel overwhelmed by his inability to understand the superior knowledge of the psychiatrist. Good supervision within the agency can effectively reduce this problem, offering the worker someone he can feel free to discuss his inadequacies with. Also, it is usually easy to tell a consultant that he is a little over the head of some workers.

Much more difficult to handle is the situation in which the consultant is not aware that his consultees' level of understanding is quite advanced. He may frequently go into minute detail on all points of a case without realizing that the agency staff has encountered the same problem many times, understands the factors involved, and needs no further explanation on the point. Social workers may be reluctant to call this to the consultant's attention, but should be no more hesitant to do this than to tell him he's talking over the heads of new workers. The agency is buying a service; it should feel free to discuss with the consultant ways in which the service can be most advantageously given.

The problem of diversity in levels of understanding is often encountered, particularly in large agencies where workers vary from 10 or more years of experience to the new employee that just came on the job. In discussing a point at one level some workers may be entirely in the dark, others completely bored. Some psychiatrists handle this very well, reflecting the staff's questions, or directing some of his own, to the more experienced workers and thus giving them the opportunity to use their understanding on the problem at hand. These consultants supply information only when it is not available from one of the staff members.

An important technique in consultation is to give the consultee an opportunity to examine his own thinking and explore his own resources for working out the problem under consideration. If the consultant answers the worker's question without first letting him tell what he knows about it the worker is being cheated and the consultant may be making an erroneous assumption as to why the question was asked.

Increased understanding on the part of the caseworker must be the result of combined effort. Often the psychiatrist simply corroborates what the social worker already knows, but the value of reassurance that one's observations are accurate should never be overlooked. Consultees should not go into psychiatric consultation with the idea that in every session they will learn something

startlingly new and different. It is more likely that "the major contribution of consultation procedure lies not in the addition of any new dynamic concept, but in the process of encouraging, stimulating and essentially freeing the caseworker to review and reintegrate knowledge, and hence more effectively to use the skills and concepts which he already possesses."[3]

At the end of a session there should be a diagnostic formulation which includes information about the child's functioning and the equilibrium of the family, if a family is involved. The worker and the psychiatrist are responsible for a psychosocial diagnosis. When the psychiatrist does not see the child this diagnosis should be recorded as "it is the psychiatrist's opinion," or "it appears to be" so that the agency will not be placed in the position of making psychiatric diagnoses.

The treatment or disposition plan for the case should be clearly understood. If the agency decides to undertake casework treatment with the child or family the psychiatrist must help to evaluate the type of treatment needed. The social staff should develop the casework treatment plan. The psychiatrist may help evaluate the plan if asked.

Following the conference the social worker should write a confirmation of the consultation and mail it to the psychiatrist. This is an excellent way for the consultant to determine whether he is communicating properly with the caseworker.

Psychiatric consultation should be sought by an agency when it is aware what it wishes to gain from the experience and ready from the standpoint of stability in administration, staff and program and when the role of the psychiatrist is clearly defined. If there is mutual respect for what psychiatry and social work have to contribute to the solution of human problems and considerable flexibility in working together, consultations can be gratifying and productive of growth in both consultee and consultant.

[3] Irving Kaufman, "The Role of the Psychiatric Consultant," American Journal of Orthopsychiatry, April, 1956.

A FOSTER FAMILY PROGRAM FOR DISTURBED CHILDREN

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The increase in the number of emotionally disturbed children and a corresponding increase in awareness on the part of professional people of the emotional factors behind the "behavior problem child" have caused reexamination of the needs of these children. The author tells how her agency developed treatment resources to meet these needs.

FAMILY and child welfare workers, probation officers, school social workers, and medical and psychiatric clinic staffs are now more keenly aware of the emotional problem as it begins to manifest itself in the behavior of the young child. Although social services have broadened to meet the needs of children, they have not expanded rapidly enough to meet the need for services in this area.

Appropriate resources for the care and treatment of these children are scarce. Residential treatment facilities for children are limited and very expensive for the average family and community to support. Child guidance clinic resources for therapy for the child in his own home are limited by the shortage of child psychiatrists, and we are often faced with waiting lists when the needful child must have treatment now.

The private agency has historically been responsible for experimentation in new fields of service and casework method. Thus, when the problem became acute in our community, it fell naturally to the Family and Children's Society in Baltimore to initiate a program for care and treatment of the emotionally disturbed child on an experimental basis. We wanted to see what would be involved in such a program and if we could make it work. The Baltimore community was aware of the need for such a program and gave us the impetus to start. Residential treatment care in Baltimore was not available for Negro children and facilities for white children were quite limited.

The experimental stage of the program began in 1951 upon recommendation of the Council of Social Agencies. We started with fourteen children, and ten months later, with full board support and interest, this program became one of our established services.

We recognized very early that we could not function helpfully without psychiatric consultation on a regular basis and were fortunate in securing the services of a skilled child psychiatrist. We used our existing casework staff which were fortunately well trained and experienced in foster care. At first we used our old, tried and trusted foster homes—one child to a home. We were also faced with finding a slow but steady flow of new homes.

Many unforeseen problems arose. We had to help our professional staff to do a more highly skilled and intensive job. We had to orient foster families to handling acting-out, extremely hostile children. We had to educate the community, police, courts, schools and neighbors to accept the child with severe problems, and the fact that it would take a long time before a change in the child's behavior would be seen. If the child's needs were being met in the foster home, we kept him there in spite of community pressure. We learned that we had to be able to bear the direct hostility of the child and foster parents. We found anxiety all around us. We had to handle not only the children's anxiety but anxious and fearful non-professional staff and jittery caseworkers. We discovered the hard way that a job doesn't run from nine to five o'clock; that pocketbooks were safe only in the hand; that hanging on tight-

* The author gratefully acknowledges the contribution of Fleda Harris, Caseworker, whose case material is used here.

ly to the back of the belt was the only sure way to hold a runaway child. We even had to have bars put on the third floor playroom window. We had been used to average, gentle and mild children, and suddenly we were confronted with acting-out delinquents with long court records. Fortunately we learned that you can't really lose a runaway child, that candy is a great healer and, best of all, that a foster mother never really means it when she says "get him out of here."

Criteria for Placing Children

To date we have taken eighty Negro and white children, aged four to sixteen years. Boys have far outnumbered girls.

The criteria for acceptance are the child's age, his degree of illness, and his capacity to live in an uncontrolled community setting.

In general, we accept boys and girls up to sixteen who have a potential I.Q. of seventy or over and some capacity to relate to an adult. The psychiatric diagnosis per se, while helpful to us in understanding the child, is not the determining factor in whether we take or reject him for our "special" program.

We reject categorically only the severe firesetter and the established homosexual.

We have been able to help a number of atypical young children ages four to eight with weak, damaged or undeveloped egos, who have never had a normal mothering experience. Naturally, our goal for these little ones in foster family care is to help the foster mother provide the even, well structured living experience and mothering that the individual child needs at his particular stage of emotional development. It is possible for the foster mother to set up the controls for the young, hyperactive child who is badly damaged but who is small enough to be handled and physically controlled when necessary.

With the nine- to eleven-year-old child we examine closely his early experiences with a mother figure and his performance in every area to decide whether he can live in a foster home. Even though he may not have had a steady relationship with a mother, if he has had anything positive from a mother figure, as evidenced by fair performance in school or in any other area, we take this as a positive factor in deciding his potential capacity to live in a foster home. We examine his ability to relate to the caseworker, what he does with his caseworker, and how he uses the tangible set-up of the agency—candy box, playroom toys, typewriter—as the caseworker gets to know him and helps him move into a foster home. If the child has a weak ego or has been very badly damaged, we realize that there is very little in relationship to the caseworker that he can take. However, any small movement is a positive factor.

Pat, an eleven-year-old boy, was referred by the public agency for placement in a foster home. Both his mother and father abandoned their seven children following a stormy life of repeated desertions and separations by both parents alternately. Pat had spent three years in a shelter home where his adjustment was so bad the first year that he was described as unable to relate to anyone, or participate in a group, and self-destructive. It was felt that he was a possible candidate for a state psychopathic hospital. He remained for a year longer, however, and began improving in school. While he still had trouble in getting along with other children he had improved, and was no longer dangerous to others. It was clear upon the second psychiatric evaluation that he did not then belong in a state hospital and was making gradual gains. Psychotherapy was recommended for him but was not available. It was hoped that within another year he might be able to live in a family setting.

Upon the third evaluation Pat showed continued improvement. While the history seemed extremely negative we felt that we could only be sure what kind of child Pat was as the caseworker began to know him. Pat was brought to the office to meet us by a male caseworker with whom he felt comfortable. On his first visit to the office he was unable to talk, sat with his head down, but showed a little interest in the typewriter, although he was unable to bring himself to use it. The caseworker was able to engage him by giving him a pencil and paper, asking him to draw a picture of a home. He drew a tower with water around it and no windows.

On a second visit to the office he was a little more open and held his head up, but when he met the supervisor he backed into the room hiding his head under his arm. Later, a bit more comfortable with the caseworker, he put a window in the top of his tower and asked some faltering questions about going to the movies and what children were permitted to do in a foster home.

On subsequent visits he added windows to his tower and finally put a front door with a path leading to it, eliminating the surrounding water. Pat's tower now

looked like a house and Pat was able to ask definite questions about a foster mother and father. He thought he would prefer to have an aunt and uncle, so we let them be aunt and uncle. He became much more outgoing with the caseworker, responding to her overtures of feeding him. After two months, his relationship with caseworker and agency was sufficiently comfortable to enable us to believe he could take on foster parents.

In foster care he needed a great deal of support and help, but his foster family was able to weather the storm of his anxiety. He went through a prolonged testing period of trying to prove that he was unloved. He made the honor roll in school the second month and also began to make friends, but it was more than a year before Pat could give up his testing and begin to trust his aunt and uncle.

In deciding whether the adolescent child can live in a foster family, we recognize that our expectation of what he can gain from a foster-parent relationship is very different from the younger child. The normal adolescent is trying to give up parental figures. His peer group and relationships outside of the family unit are becoming more important to him. Thus, in considering whether to take a child of adolescent age, we not only look carefully at his earlier experiences and current behavior and performance, but we place much more importance upon his capacity to establish a relationship with his caseworker. The caseworker will have to have a strong helping and holding relationship with the adolescent child because she will be the important, stabilizing person in his life. She will be his friend and his authority. To the adolescent, as well as to the disturbed younger child, the agency setting, playroom, pediatrician, clothing worker and supervisor take on importance and offer the emotional support he needs. The strength of relationship with his caseworker, however, can determine how he accepts and uses the total agency. There are times when it seems like the agency office is a second home to the older child during periods of stress.

How Children Are Referred

Children are referred for our "specialized" foster family care from the court, the school, psychiatric clinics, and other divisions of our own agency. The public agency also refers children who are too disturbed to live with regular foster families. The children referred by the public agency have been adjudged dependent and neglected, and many of them have been found delinquent. Some children referred by the public agency have been deserted by one or both parents. Parents whose children are living with them may also make voluntary application to Family and Children's Society for care for their child. We serve them if we believe they can work with us responsibly and help the child by supporting him emotionally in the placement.

Our primary goal in working with parents is to help them become better parents, to develop understanding of the child, and to meet his needs after a period in foster family care. We have found to our dismay that too often the parents of the children we have taken are so badly damaged themselves that they cannot use our help in changing their attitudes and feelings towards their children. Our minimum goal is to try to preserve in the parental relationship whatever can be positive for the child and parent—even to the barest thread of interest—a letter, a birthday or Christmas present.

We encourage monthly visits between child and parents supervised by the caseworker in the agency playroom. The caseworker's presence here can be a real help to both parents and child by keeping conversation on a safe level. She can jump in to cushion the hurt feelings of the parent when the child becomes hostile or will not talk. She can be with the child and help him with his feelings of ambivalence and confusion when the visit is over. Visiting plans are changed, however, in relation to their diagnostic soundness for child and parent. A few parents have the strength and emotional control to visit in foster homes. Sometimes, older children are able to visit their own families. If the going gets rough for them emotionally, they can leave and discuss it later with the caseworker.

Criteria in Choosing Foster Parents

We pay our foster families a weekly board and provide medical and dental care, cloth-

ing, incidentals and allowance for the child. We expect foster parents to have an active church affiliation and to meet the age requirements and physical and emotional standards set up by the State Department of Welfare. We select foster parents for these children who have had experience in rearing children; they must have a good concept and experience with children from infancy through adolescence. We know that the disturbed child whose emotional needs have not been met requires the undivided attention of the foster family so that our usual procedure is to place only one child in a foster home. We have found that the foster parents who can take acting-out, hostile behavior must have a deep understanding of the child's illness and a strong wish to stick with him and see him through. Usually, those families who have been able to stand the impact of almost overpowering hatred are those who themselves have known a deep and painful emotional experience. Coming through this successfully, they have gained unusual maturity and are more secure in their capacity to help a sick child.

Mr. and Mrs. Barnes, ages fifty and fifty-one, a childless couple, had been married twenty years and had a mature, comfortable relationship with each other. Since coming to the community in their early forties they had applied to several agencies to adopt a child, but were rejected repeatedly because of their ages. Finally they applied to board a disturbed older child, again with deep fear that they would be rejected. This home study revealed them to be sincere, unassuming, comfortable people who had given devoted interest and care to children of relatives and friends.

In spite of their deep sense of inadequacy because of the way that agencies rejected their adoption requests, and their own inability to have children, they had basic security and strength. The hurts that they had sustained enabled them to feel deep sympathy and sensitivity to the needs of hurt and deprived children. As much as they wanted to be mother and daddy to a child they were willing to become "Aunt Vi" and "Uncle John" and live through a year of rugged testing and rejection by Pat before he could begin to trust and accept that they cared for him.

The foster mother really has the major job to do with the child. Since the child's illness has usually resulted from rejection by the mother person, or a complete lack of giving from a mother, the hostility is certainly strongest toward mothers. The foster mother therefore becomes the target for his hatred and must be able to endure repeated outbursts of anger without rejecting him. To bear this, she needs a tremendous amount of support. The foster father offers an excellent figure for identification and is the supporting person to the foster mother. The caseworker also takes on this supporting role with the foster mother. She becomes the authority and mainstay for both the foster parents and the child.

Preparing the Foster Family

Preparation of the foster family for the child must be thorough and honestly descriptive of the child's experiences and behavior. With this beginning, the relationship between caseworker and foster parents develops surely and solidly. However, we know that no matter how much actual detail we give them ahead of time about the child's behavior, they do not know how it feels to live with a deeply angry child until they have experienced it. It is then that the caseworker and foster family begin to share a painful but exciting experience. Foster families inevitably feel responsible for the child's outbursts of disturbed behavior and are inclined to blame their own mishandling for it. The caseworker here can relieve the guilt by reminding them that she had expected this, as she had described this kind of behavior to them earlier; that they are not responsible for the current outburst. The caseworker must get across to the foster family from the beginning that the care of the sick child requires that caseworker, foster mother, consultant psychiatrist, and pediatrician work together as a team. As the parents' experience in working with the agency deepens, agency support broadens to include the supervisor, the clothing worker, and often even the switchboard operator. We have found that as children use various people in the agency in their own way, so do foster parents. They need steady approval, reassurance and help in seeing every small bit of improvement, be it ever so minor, if

they are to survive the testing, heckling and tormenting of the acting-out child. Because the caseworker maintains a close relationship with her and with the child, the foster mother knows through actual experience that we understand what she is going through. Inevitably the anxious, upset child will reactivate in the foster mother feelings about an earlier experience with her own mother, siblings, or children causing her to become anxious and often guilty. Here she needs help in recognizing the difference in the foster child's situation and in separating and understanding her feelings.

The foster families are usually proud of their status in the community, their position in church, with neighbors and friends. They can take the strain and frustrations of living with a disturbed child, but they cannot stand the additional burden of criticism from the school, neighbors or police. The caseworker has to carry direct responsibility for the child in the community and deal with the hostility of other people affronted by the child's behavior.

Joe, thirteen years old, was determined to prove that Mrs. Healy, his foster mother, would reject him, or weaken and be completely controlled by him. These were alternating patterns he had lived through during his twelve years with his mother. He tested Mrs. Healy in every way possible to trap her into meeting his deeply neurotic need for rejection. He brought home stray dogs and found a way to injure them. He dug up all the roses in her cherished garden. When this failed to arouse her rejection, in one temper tantrum after another he broke her china closet door, smashed dishes and became so destructive every day for a period of a few weeks that we really wondered if we could keep him in care and how in the world Mrs. Healy stood it. The psychiatrist who was treating him felt it was essential for Mrs. Healy to remain steady and not fall into the traps he was setting for her. When she withstood this test, Joe took another approach to destroy his foster mother. Knowing how important her church connection and her standing in the neighborhood were to her, he went to neighbors and friends describing the Healy family's personal habits as filthy, and claiming that he was mistreated by having to sleep with bedbugs on dirty sheets in a roach-infested house. He was so convincing that Mrs. Healy found herself ostracized by her friends. Some of the church members cut her dead on Sunday.

Then reports began to come in to the agency. The caseworker lost no time in getting to every former friend and neighbor of Mrs. Healy's and also letting her know that we would defend and protect her in her community as far as possible. It was a hard job to convince these people that Joe was trying to manipulate them into doing exactly what they had done—hurting Mrs. Healy. Through describing Joe's behavior in other areas to the neighbors, we were able finally to get across to them that Mrs. Healy was exactly as they had known her before, and that she was doing the community, the child, and the agency a tremendous service by living through this difficult testing period with Joe. A few months later Joe had calmed down enough to be sent to camp and while he was gone we were able to demonstrate tangibly to the neighborhood our trust in Mrs. Healy by placing two children with her for a temporary period.

The Role of Intensive Casework

While our foster parents are described as "specialized" because we have carefully selected and prepared them, the truly specialized ingredient in working with these children is the high degree of casework service.

The caseworker is able to carry between twelve and fifteen children in foster family care. This number also depends on the adjustment of various children in her case load and the distances she has to cover. In general, the child and foster family are seen once a week. For several weeks after the placement of the child, however, contacts are more frequent and we have found that the foster mother needs frequent telephone interviews. It is reassuring to the foster mother to be able to call the caseworker, or in her absence, the supervisor, on a twenty-four hour basis so that she has much needed support in a crisis. It takes many a midnight phone call before a foster family can believe that a runaway child will be found.

More than half of the children in our care have received psychotherapy. The caseworker carries this with the psychiatrist or clinic, taking the child to the psychiatrist and working intensively with the foster mother during this period. The caseworker also carries responsibility for medical and dental work for the child with the help of medical workers who assist with details of transportation and clinic routines.

Every child is discussed at intervals with the consultant psychiatrist, who is kept

aware constantly of changes in attitudes, feelings, and symptoms. All of the caseworkers participate with the psychiatric consultant in weekly case discussions from the point of referral and application throughout the child's placement experience. These group meetings are extremely helpful to the staff in understanding the dynamics of behavior and how to be helpful to the parent, child and foster family.

In order to meet the individual needs of the children in our care we have used all of the resources offered by the community. We have used for limited periods private tutoring, public school home teachers (until the child can get into school), camps, and public and private recreational facilities. We have turned to child guidance clinics and to private psychiatrists to treat our children. We have become experts in placing turtles, fish, dogs, cats, pigeons and bicycles. The children in our care have come from such emotionally and materially deprived backgrounds that in foster family care we have used every resource to support and enrich their lives. If they have any talent in music, singing, or art, we do what we can to encourage and train it when the child is ready to take it.

The results have been rewarding. Although some children have been too deeply damaged to live in the open community, we have tried to plan for them as appropriately as possible through placement in hospitals and training schools.

More than thirty children have left our care. A few have been able to return home and are getting along satisfactorily. Seven girl graduates have married and seem to be making the grade. Boys, in general, join the service when they have reached enlistment age. Some boys have become totally self-supporting and remained on in their foster homes. For most children, the foster family and the agency continue to represent security. Many return to their foster homes on holidays and vacations, and keep in touch with us through letters and occasional visits until they gain enough maturity and satisfaction in their lives to need us no longer.

Exchange Social Workers

On occasion the Child Welfare League has been asked to suggest agencies that might be interested in temporarily employing social workers from Britain. Usually these are well trained and experienced people who are interested in a particular type of experience for a period of a year or two. The organization sponsoring this program is known as the British Committee for the Interchange of Social Workers and Administrators.

Interested agencies should write directly to Mrs. N. Rice-Jones of the British Committee, at 26, Bedford Square, London, W.C. 1, England.

ANALYZING A STATEWIDE ADOPTION AGENCY'S STATISTICS

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This paper reports on a study analyzing service statistics on placements made over a six-year period, 1951-1956, and interprets trends and the thinking behind them.

A RECENT study of adoptive placements by the Washington Children's Home Society[1] revealed several significant service trends. The introduction of new methods and the streamlining of others, following reexamination of practice by the board and staff (particularly since 1953) have tended to accelerate certain trends in the agency's adoption service.

The State Board of Trustees carries overall responsibility for administration of the agency. In each district there is a branch board responsible for local management and supervision within the framework of policy adopted by the Board of Trustees. The agency's executive, known as the State Director, is employed by the Board of Trustees. In carrying out his responsibility for securing and maintaining adequate staff for the agency, he employs branch executives with the advice and consent of the appropriate branch board.

The Society's adoption work in recent years can perhaps be seen best in relation to the statewide adoption picture, including both agency and "independent" placements. In Washington, each year since 1950, the state public welfare agency has collected statistical data on adoptions completed through the courts.[2]

The 1950 report showed 828 adoptions of children by unrelated persons in which the person or agency making placement was known; thirty-six percent of these had been placed by approved social agencies; thirteen percent of them had been placed by the Washington Children's Home Society. In 1956, nine hundred thirty-seven adoptions were reported in the same category; 58.2 percent of these children had been placed by the approved agencies; 23.5 percent by the Washington Children's Home Society. These statewide figures show that Washington is making progress, although at a slower rate than any of us would wish, in bringing more of its adoptions under agency auspices. The figures also show that the Children's Home Society has been doing an increasing share of the growing number of adoptions in the State.

Statistical comparisons of the Society's placements from 1951 through 1956 reflect one major program development within the Society, several important changes in the Society's practices, and certain shifts in the services of other agencies.

The figures in Table I show that there was a considerable increase in the number of infants placed from 1951 through 1956, and that larger numbers of children of all ages were placed in 1954 and 1956 than in any other years.

Largely responsible for the increased number of infant placements was the agency's maternity care service, begun experimentally in 1949, and expanding at an accelerated rate by 1952. This program of care and counsel is available both to unmarried mothers and to those who have been married and are pregnant out of wedlock. This service has grown as rapidly as budgets could be secured. It is an out-patient service which supplements the programs of social agency ma-

[1] Established in 1896, the Washington Children's Home Society is the only voluntary nonsectarian agency in the state providing both adoptive placement for children and maternity care for unmarried mothers on a statewide basis. Its third function is group care and casework services for school-age children and adolescents in small living units.

[2] Because the reporting is not mandatory, some counties fail to report and others report incompletely; however, those most familiar with the data estimate that 90 percent of the completed adoptions are now being reported, although the percentage was probably considerably lower when the reporting program first began.

Table I
Number and Ages of Children Placed for Adoption

Age at Placement	*1951*	*1952*	*1953*	*1954*	*1955*	*1956*
Total	188	259	268	312	282	295
Under 1 year	136	182	196	233	223	239
1 through 5 years	34	52	55	66	41	41
6 years and over	18	25	17	13	18	15

ternity homes in the state. The Children's Home Society provides no group care for unmarried mothers, but assists each with individual living arrangements, in a family wage or boarding home, in her own home, or with friends or relatives. Skilled casework service and private obstetrical and hospital care are the core of the program. Initially the service was offered only in Seattle; since 1955 it has been available through all the agency's branches.

Sources of Referral

Statistics show that approximately four out of every five mothers whose babies are born under this program relinquish their children for adoption through the Children's Home Society. Although comparable statistics are not available for the early years of the program, those for the past four years alone show the effect of the development of this service upon the Society's adoption service. During 1953, the maternity care program was the referral source for sixty-one of the infants placed in adoptive homes. In 1956, one hundred fourteen infants came into adoptive care through this program. These additional infants, coming through the agency's own maternity care department, more than accounted for the absolute increase in the number of infants placed for adoption shown in Table I.

The approved maternity homes in Washington, which do no adoptive placement themselves, have always been a major source of referral of infants needing adoption. The number of infants referred for adoption by these homes has fluctuated in the past four years due to at least two factors external to the Children's Home Society. In 1954, another adoption agency suffering severe staff problems temporarily closed its intake, thereby diverting to Washington Children's Home Society for placement a much larger number of infants from maternity homes. In 1956, the closing of one maternity home had the dual effect of decreasing our child intake from that source and increasing our admissions for maternity care.

Table I shows that the number of children above infancy has not kept pace with the overall increase. The principal reason for this appears to be the beginning of the adoption program of the State Department of Public Assistance in 1950, which concentrates largely on the placement of older children. Comparable data on the sources of referral of children placed for adoption by the Children's Home Society were readily available only for the past four years. It was found that in 1953, of seventy-two children over one year of age placed for adoption, forty-two had been referred by the Department of Public Assistance through its county offices. By contrast, in 1956, only eighteen of the fifty-six children in the same age category who were placed had been referred by the county offices of the public welfare agency. The decline in referrals of older children to Washington Children's Home Society from this source more than accounts for the total decrease in the number of these children placed in 1956 as compared to 1953.

Adoption Fees Add Income

A system of adoption fees which was put into operation in January, 1952 added income which enabled the agency to augment its staff and to provide more service in both adoption and maternity care. From its effective date through the remainder of our study period, the adoption fee was $200 per placement[3], with provision for reduction or waiver as needed. In 1952 the fees provided a little less than eight percent of the statewide budget of $363,510; in 1956 this no-longer-new income source met 9.6 percent of a budget of $504,552.

[3] Effective July 1, 1957, the fee was increased to a maximum of $300.

Table II
Number of Infants Under One and Two Months of Age at Placement

Age at Placement	*Total*	*1951*	*1952*	*1953*	*1954*	*1955*	*1956*
Under one month	124	2	10	20	24	25	43
Under two months	239	2	14	21	36	62	104

Tables II and III reflect the agency's cautious movement toward earlier placement of infants from 1951 to 1954 and, from 1955 forward, its strengthened conviction that as many infants as possible should be placed in adoptive homes early.

Table III
Infant Placements by Median Age of Child

Year	*Number*	*Median Age at Placement*
1951	136	4 months, 5 days
1952	182	4 months, 8 days
1953	196	4 months, 2 days
1954	233	3 months, 21 days
1955	223	2 months, 26 days
1956	239	2 months, 9 days

Until 1954 it was agency policy to wait for each infant's evaluation by one of the clinical psychologists who served as consultants to the agency. Because two months was the earliest age at which the psychologists felt able to test, and because in many cases retests were recommended, the average age at placement was considerably over the two-months level. As the figures for the years just prior to 1954 reveal, however, there was a gradual relaxation of policy regarding preplacement testing when the child's caseworker and supervisor believed that earlier placement could be risked with an individual infant. At first, in such cases, the adoptive parents were required to have the child tested by the agency psychologist before completing legal adoption. Later, exceptions to this requirement were also made.

The Society's medical program has been considerably strengthened since 1954. This has been another factor in lowering the median placement age for infants. Earlier and more complete medical diagnoses have allowed the casework staff to move ahead in finding families for children with minor and sometimes major physical handicaps—families who are often eager and willing to see the children through whatever correctional work is needed. The casework staff has also worked consistently toward choosing adoptive families who have a wider range of acceptance for children with physical defects and those of mixed race. This work has resulted in earlier placement for some of these "special" children.

For several years the professional staff of the agency, including its pediatric and psychological consultants, put a great deal of effort into establishing, evaluating and revising the criteria by which infants could be selected for placement as early as four or five days of age. By 1956, the criteria to be met by those infants selected for very early placement were these:

1. The history on both sides of the child's family indicates that the child will be at least of average potential. Factors taken into consideration include the success of parents and other relatives; whether the family health history needs further evaluation and consultation; and evidence of mental illness or a history of retardation in the family, which call for inquiry into the causes of these conditions and their frequency in the family.
2. Normal pregnancy and delivery.
3. Pediatric report that the infant, while in the hospital nursery, gives every indication of being a normal, lusty newborn, including good cry, good appetite, absence of jaundice, cyanosis, and birth injuries.
4. An unwavering decision on the mother's part regarding relinquishment; relinquishment completed.
5. Absence of possible legal complications such as existence of a legal father.

Acceptance of the above criteria has meant holding for further observation and psychological testing only those infants who do not meet the first three criteria.

Measuring Success of Earlier Placement

Objective testing of criteria like these and measurement of "success" in adoption are difficult without a comprehensive research

process involving both adoptive parents and children on a long-range basis. However the data on children returned to agency care from adoptive homes may be regarded as one rough measure of success. By this yardstick the Society's early adoptive placements, and in fact its infant adoption service as a whole, appears to measure up very well. Investigation revealed that in six years (from July 1, 1951 through June 30, 1957) thirteen children placed by the Society as infants were returned by their adoptive parents or were removed from adoptive homes by agency action. This number—slightly over one percent[4] of all infants placed between January 1, 1951 and December 31, 1956—included none of the one hundred twenty-four children placed at less than one month of age and only one of the two hundred thirty-nine children placed at less than two months of age. In this single case the adoptive mother became seriously ill and the child's development was in no way the cause of his replacement.

In this study, the agency was also interested in taking a look at its progress in reducing the waiting period for the people accepted as adoptive applicants.

Table IV
Median Length of Time Waited by Adoptive Families

Year	*All Families*	*Families Who Received Infants*	*Families Who Received Children 1 Year and Older*
1951....	27.4 mo.	27.8 mo.	24.5 mo.
1952....	24.4 mo.	24.7 mo.	19.5 mo.
1953....	22.9 mo.	23.5 mo.	18.5 mo.
1954....	19.7 mo.	19.7 mo.	19.5 mo.
1955....	18.3 mo.	18.7 mo.	13.0 mo.
1956....	12.4 mo.	12.5 mo.	11.5 mo.

Table IV shows that adoptive families formerly waited a very long time between application and placement and that, particularly beginning with 1954, this waiting time has been markedly shortened. The reduction in time resulted from several changes the Society made in 1954 in working with applicants from the point of initial inquiry.

Change in Handling Applications

The agency board and staff had long been dissatisfied with the old system under which, after a screening interview and written application, applying couples were added to a constantly accumulating waiting list. This list at times numbered more than eight hundred fifty couples at the end of a month. Because only two hundred to three hundred homes could be studied and used each year, client dissatisfaction and public relations problems mounted; the pressure of waiting applicants was a burden on every caseworker.

The new way of working with adoptive applicants resulted from several months of intensive study by board and staff, and consultation with other agencies, including the Boys' and Girls' Aid Society of Oregon. To put its house in order as much as it could before putting the new plan into operation, the Society closed its intake of adoptive applications for four months and all adoption caseworkers made a concerted effort to weed out "dead wood" from their loads, and planned to complete all remaining home studies as soon as possible.

The first change in the adoptive process was the addition of an orientation meeting to which couples are invited shortly after making their first inquiry about adoption. These meetings, we have found, are of considerable value in involving people early in a process of self-selection or self-elimination as applicants, and in permitting more effective use of the agency's first personal interview with each couple who choose to take the next step.

The second change was in what happens to new applications. Formerly each was assigned immediately to the caseworker in the district where the family lived. Now, a monthly review of all newly filed applications is made first within each district and subsequently in the state office. The worker who has had the first interview recommends acceptance for further study or rejection. The district staff considers this and also has

[4] EDITOR'S NOTE: The Final Report of the Citizens Committee on Adoption of Children in California states that twenty percent of independent adoption placements were never legalized.

access to the completed application form, the medical fertility report, and the caseworker's recording. The district recommendations are then sent to the state office where a central staff committee of three supervisors and senior workers, knowing the statewide picture of potential need for homes (based on ages, race and special need of children), is responsible for keeping applications in various districts within an encompassable load. Following each monthly meeting of this committee, each applying couple receives word by letter from the district office as to whether their application is being continued for study or discontinued.

In the first year, one out of every three applications was discontinued due to the sheer weight of numbers; in 1956 it was necessary to discontinue only one out of five. In the latter year the average number of applications pending and under study was three hundred eighty-five—a more realistic number than the eight hundred fifty carried three or four years earlier. Although there are good families lost to our children through this process, the Society believes that the long-range effects upon both service and public relations have been beneficial. With fewer applications to process, caseworkers can start and finish most home studies within six to ten months after application has been filed. Among those families who received children in 1956, forty-seven percent had waited less than one year. By contrast, in both 1953 and 1954, only sixteen percent of the families had waited so short a time as this.

Summary

The trends which have emerged most sharply in the past three to four years have been toward adoptive placement of more children of all ages except school-age; earlier placement of infants; acceptance of fewer adoptive applications for continued study; and shortening of the waiting period for the adoptive applicants who are served by the agency. The board and staff of the Washington Children's Home Society believe that creditable progress has been made in strengthening the agency's adoption service within this period, but they see still more to do. The Negro children and children of mixed race, who are waiting for families, are the object of deep concern. A special community organization effort in homefinding for these children is just getting underway. The casework staff has been working for some time on an examination of our practice in studying adoptive families and in supervising after placement. As from our other self-study efforts, it is hoped that further refinement and streamlining of the adoption service will result.

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Community Factors Affecting Foster Care

The growing concern about the many unsolved problems in community planning and practice involved in providing care of children away from their own homes, leads us to suggest that both public and voluntary agencies might well review the Children's Bureau publication entitled Child Welfare Reports no. 9, issued in 1956, which reports the problems and needs in the field of foster care, as seen by state public welfare agencies.

The following excerpt from this pamphlet is basic material in considering unmet foster care needs of any community.

> Foster care services are affected by prevailing social and economic conditions, since these determine, in large part, both the need for foster care and the resources available to meet the need. According to the State welfare agencies the following are the most important community factors affecting foster care services today.
>
> (1) The tremendous growth of the child population of the Nation has not been matched by a parallel growth of child welfare services.
>
> (2) The mobility of the American people—involving as it does the disruption of family life, the lessening of individual and family ties to any one community, and a host of personal and social problems—has a direct impact on the need for foster care. It also affects the administration of foster care services and the use of resources.
>
> In areas of defense and military activity one finds transient populations in which problems such as illegitimacy and child neglect are likely to be severe. Many defense and other industrial developments are

occurring in areas formerly rural, where previously existing social welfare resources are grossly inadequate for the new demands.

(3) Increasing industrialization and urbanization is often accompanied by "growing pains," representing new, unsolved problems. Particularly where industrialization is rapid—as along the southeast Texas coast, in the Pittsburgh region, in Delaware—there is likely to be a need, sometimes acute, for child welfare services. The vast increase in employment of women bears most directly on day care but affects the need for full-time foster care as well. It is more difficult to find foster mothers when employment of women is high; and the high cost of living, a factor contributing to women's working, affects the relative adequacy of present board rates in attracting foster parents.

(4) The population exodus to the suburbs, again areas where pre-existing resources are not well developed, likewise creates a need for services of all kinds to keep pace with the growth in population.

(5) Housing problems increase the need for foster care and decrease foster care resources. Where housing conditions are extremely bad, they contribute to the breakdown of family life and to the demand for child welfare services. A housing shortage, particularly a shortage of homes with spare rooms, makes foster home finding difficult.

(6) Depressed areas, where social problems abound and resources to cope with them are grossly inadequate, are found in widely dispersed parts of the Nation. These include communities left stranded by World War II, economically depressed counties in southern Illinois, depressed coal field areas in Kentucky, Rhode Island communities that have lost textile mills, and others.

(7) Some social problems are especially characteristic of certain population groups and in certain areas. In Alaska, for example, the widespread prevalence of tuberculosis and the consequent hospitalization of parents creates a special need for foster care. Puerto Rico's strides toward industrialization have brought all the characteristic problems of highly industrialized societies including family disruption and child welfare problems. Changes in Indian culture, family life, and the resources of Indian tribes have affected the child welfare needs and resources of these groups.

(8) Miscellaneous other factors were cited by the State welfare agencies—the rise in illegitimacy, seasonal employment in some areas that makes temporary foster care necessary for certain children, the complex problems of children and parents today that is attributed to pervasive social stresses, and growing awareness and concern about the needs of children generally.

The entire pamphlet is one to be studied.

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EDITORIAL COMMENTS

Some Problems of Communication

THE ability to communicate knowledge, questions, problems and achievements is essential for the development of every profession. While it is now commonly recognized that words can obscure as well as reveal true meaning, all the social science-based professionals continue to be troubled by this problem.

The complexity of human behavior and the fact that it does not lend itself for study under the microscope add to the problems of social workers both in evolving and in communicating basic concepts. This is particularly true of concepts that have their roots in allied fields of knowledge—medical, psychological and sociological. Are we held so close to our immediate tasks that we have not the time to study the multiple implications of our concepts? Anna Freud once said that we are so eager to add to our knowledge that at times we take on ideas which we only partly understand.

We may use words and phrases that convey meaning only to those similarly oriented, though even here some questions could be raised—evidence the difficulties in interagency communication. True, every profession develops words, or imputes special meaning to words. With the profession it may serve as an economy in communication. Social workers are no exception. However, a problem occurs when such special usage tends to crystallize not only the concepts but our reactions to them. In effect, we create categories of people or circumstances. This interferes with our goal to see the uniqueness of each situation and treat each person with respect for his individuality.

Here are a few terms we commonly use. I suggest that we examine their influence on our approach.

1. Rejecting parents—does this spell "hopeless"?
2. Neglected children—do they need above all else to be saved?
3. Parents who do not *want* help—might as well leave them alone?
4. Parents who are not reachable—what use trying to enlist their participation?
5. Emotionally disturbed children—let's find residential treatment?
6. Very disturbed parents—can't count on them?
7. Parents of low intelligence—can't expect anything from them?
8. Retarded child
9. Handicapped child
10. Older child

   } very little hope for these parentless children ever to have a permanent home by adoption?

11. A large family of children—can't consider each child's individual needs?
12. Others—please specify.

It could be not only illuminating but a spur to improving service if we would try to analyze what these terms mean to us and what action they lead to. Perhaps such an analysis could lead to broadening our approach. CHILD WELFARE could open a page for examining such thinking and practice—under the caption *Views and Reviews*.

H.L.G.

BIRTH HISTORY IN EARLY ADOPTIVE PLACEMENTS

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Rita Dukette,
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This paper discusses ways in which agencies can place infants soon after birth, while still maintaining the careful standards which have resulted in a much higher rate of success than that of non-agency placements.

MOST ADOPTION practitioners are becoming convinced of the importance of placing infants permanently as early as possible. Many agencies are finding ways to accomplish this. What relationship does background information and birth history have to this goal? Some agencies are placing children in the first weeks of their lives only when the history is complete and without known pathology. Others pay relatively little attention to history, referring optimistically to the happy outcome of many early placements. One of the advantages of agency placements over private placements has been the safeguards provided by careful study of the children placed, with the risks those inherent in the future development of any child and not those resulting from lack of knowledge which could have been gained.

All early placements must of course be preceded by careful and knowledgeable study of adoptive families. No safeguards concerning the child will be of any avail if the adopting parents have conflicts about adoptive parenthood or are in other ways unready to enter into this relationship or assume its responsibilities. For the purpose of this discussion we will assume that this part of the task has been adequately accomplished, not only to determine capacity for adoptive parenthood but also to know what factors about a child and his background hold value or stress for the applicant so that the selection of a child can be appropriately related to these facts.

Background history tells us what the child may have been given from his family. But more specific understanding of what he may be like as an individual comes from knowledge about his prenatal and birth history. This data must be obtained from and evaluated by the obstetrician and pediatrician, but knowledge about significant factors and their possible implications is one of the essential working tools of the caseworker placing young children. The mother's health and emotional states during pregnancy are believed to affect her baby's physiological adjustment. Though our knowledge is still incomplete, a number of scientists are contributing studies, including that of the Fels Institute, demonstrating that nervous changes in the mother may affect the fetus. Their general conclusions are that prenatal stimulation caused by chemical changes in the mother may cause the child to have an irritable, hyperactive, autonomic nervous system.

Pre-Natal Experiences

Before the baby is born he has already had experiences which will affect the way he adapts to the world.

"We assume that intra-uterine growth involves the continuous gratification of basic needs, sheltered from external disturbances. However, not only the physiological processes of the mother favorable for the growth of the fetus are transmitted; more recent investigations indicate that fluctuations in the mother's physical and emotional well-being may also be registered by the fetus. Such influences, as well as the effects of the obstetrical techniques, may modify the newborn child's adaptability to extrauterine life."[1]

"Some confirmation that prenatal effects may occur was offered in a study by Sontag in which correlations were found between excessive hyperactivity of the newborn (crying, sleeplessness, regurgitations, etc.) and maternal emotional stress during pregnancy, as well as between infant serenity and a normal, contented pregnancy. Since it has been shown that reactions at each

[1] Therese Benedek, "Personality Development," *Dynamic Psychiatry*, ed. Franz Alexander, M.D., and Helen Ross, University of Chicago Press, 1952.

age are dependent in part upon the status of personality development which has grown out of reactions to previous experiences, these studies suggest that the infant probably enters the world with constitutional trends already modified by the impingement of the environment upon him while he was still in uterus."[2]

In addition to the possible effects of the mother's emotional stress, the fetus may be affected by physical circumstances such as pressure, radiation, nutritional deficiencies which may result in poor or abnormal development, the mother's use of drugs such as quinine or morphine, or large doses of barbiturates prior to delivery. It is important to know the timing of such experiences in evaluating their possible effects on the fetus. The significance is generally known of a number of virus and bacterial diseases including syphilis and German measles (Rubella) which may result in a handicapped child, depending partly on the time of their occurrence during pregnancy. It is also known that diseases of the mother such as hypo- or hyper-thyroidism and diabetes may result in compensatory hormonal imbalance in the fetus with devastating effect as the infant assumes independent existence. Rh incompatibilities, when not responsible for fetal loss, may result in neonatal death, or subsequent central nervous system damage due to severe anemia or kernicterus.

Effect of Birth Process on Child

The birth process is more or less stressful for the child, and is another environmental circumstance to which he must adapt, by either temporary or permanent change depending on his characteristics and upon the degree of stress involved. This stress comes from the mechanical process of birth and also from the adjustment the organism must make to a radically different and less benign environment.

In so-called normal birth, the fetus is in the uterus for forty weeks; at the end of that period, labor begins spontaneously, culminating in delivery of the child usually in vertex presentation with occiput anterior, (with the head first and the face down), within eighteen to twenty-four hours in a first pregnancy. Even under these conditions, the most felicitous for the child, there is considerable duress.

The factors in delivery which should be known in order to evaluate the stress of the birth include: length of gestation; whether labor was spontaneous or induced, and if the latter, how; length of labor, including the duration of its stages; time of the rupture of the membrane; whether delivery was spontaneous or surgical (with detail concerning the use of forceps); the position in which the baby was presented; and the amount and kind of anesthesia used. The significance of these data should be evaluated by the baby's pediatrician. It is important for the social worker to understand their possible implications as she continues to study the child's development and adjustment. Many of these facts, especially when there is no gross observable evidence of the stress of birth, are significant, not as precursors to inevitable trouble, but because they provide an understanding of individual differences and of any difficulties which may appear in the first few weeks or months. If the birth history includes circumstances known to have possible complications it may seem wise to observe the child a little longer than if the course had been uneventful and to choose parents who do not have anxieties this history might aggravate.

Premature birth is one deviation from normal delivery. Its complications result primarily from curtailing intra-uterine existence before maturity. "For practical considerations an infant who weighs five pounds, eight ounces (2500 grams) or less at the time of birth is defined as a premature infant."[3] There are some racial and sex differences, with white males apt to weigh most, white females somewhat less, with Negro and Oriental races in general apt to be lighter.

[2] Margaret W. Gerard, "Emotional Disorders of Childhood," *Dynamic Psychiatry*, ed. Franz Alexander, M.D., and Helen Ross, University of Chicago Press, 1952.

[3] Mitchell and Nelson, *Textbook of Pediatrics*, ed. W. E. Nelson. Philadelphia and London: B. Saunders Co., 1950.

"The premature infant has less resistance and greater susceptibility to illness and his recuperative powers are less than those of full term infants. Congenital malformations are also relatively more frequent; in some instances they may be directly responsible for premature birth and also for neonatal death.

"Varied statements have been made in regard to the ultimate physical and mental development of the infant who was born prematurely. In general it would appear that average development can be expected if the physiological development at birth was normal for the fetal age and if there was no congenital or neonatal disturbance which left a permanent and deleterious effect. Allowance must be made, of course, for a delay in development during the first few years of life. Such differences usually disappear by the third birthday although occasionally the process of 'catching up' requires a longer period without indicating a continued deficit in development."[4]

Blindness due to retrolental fibroplasia has been one of the hazards of prematurity, but with recent knowledge about concentration of oxygen in the incubator, this is usually a preventable circumstance, though it is still a matter of concern.

The difficulties of postmaturity are less often considered but may also be significant, since the larger fetus may cause mechanical difficulties in birth which may result in damage.

If drugs were necessary to induce labor there is a possibility of cerebral damage. The toxic properties of quinine may affect the fetus. The use of pituitrin may cause anoxia or deprivation of oxygen because of the severity of the uterine contractions. Mechanical methods of inducing labor are now more rarely used. Their hazards lie in the danger of infection. Information about the length of labor, especially the second stage, is of particular significance because of the potential damage when this is prolonged, from excessive pounding and possibility of anoxia. The rupture of the membrane early in labor causes a more difficult birth, for lack of lubrication increases the mechanical difficulty and the possibility of an infection or aspiration of amniotic fluid. Normally, the baby is presented in a vertex position with occiput anterior. Presentation in other positions increases the possibility of damage both because of the greater possibility of injury and because of the danger of oxygen deprivation.

"It is of special interest that the pediatricians have made the general observation that there is a high degree of pathology (injuries to the neck, disorders of breathing, and many other disturbances) among babies born by breech presentation but this subject has not been carefully studied."[5]

Effects of Instrument Delivery

The child is more likely to experience a difficult delivery when mid or high forceps are used. The danger of instrument delivery is that the labor may have been difficult enough to have caused cerebral damage, ranging in severity from minimal hemorrhages, which clear soon after or even before their effects are seen in development, to vast and incapacitating damage. In cerebral injury "the behavioral gravity of any injury . . . depends on the extent and site of the lesions."[6]

Caesarean birth might seem easier for the child but requires adjustment to a rapid change in pressure. The circumstances of a Caesarean birth may be less felicitous than those of a normal birth, involving more difficulty in establishing breathing and more possibility of cerebral hemorrhage.

The kind and amount of anesthesia used is significant because of the possibility of oxygen deprivation for the child. "Even very brief periods of oxygen deprivation may have pronounced and persistent effects upon the functioning of the nervous system because of destruction of brain cells,"[7] and although "Fetal neonatal subjects have long been recognized as able to withstand degrees of anoxia intolerable or much less tolerable to the adult organism . . . even though survival is possible, there is also great danger of permanent damage."[8]

[4] Mitchell and Nelson, *op. cit.*

[5] Phyllis Greenacre, "The Economy of Birth," *Psychoanalytic Study of the Child*, Vol. I. International Universities Press, 1945.

[6] Arnold Gesell and Catherine Armatruda, *Developmental Diagnosis: Normal and Abnormal Child Development*. New York: Hoeber, 1947.

[7] *Ibid.*

[8] Clement A. Smith, *Physiology of the Newborn Infant*. Springfield, Ill.: Charles C. Thomas, 1945.

Another study of the general schedule of postnatal adjustment has shown how rapidly and efficiently the blood oxygen content may be re-established in infants who have undergone periods of seven or even fourteen minutes of complete apnea after birth.

"These particular infants are known to have made apparently normal subsequent progress in development which is testimony to their ability to withstand anoxic insult. However, one is curious as to the later growth and development of every such infant . . . Schreiber and others have collected much evidence to indicate that the human central nervous system, although capable of survival after anoxemic insult may often be thereby rendered incapable of achieving normal function."[9]

Summary

If the child's birth history has been unusually stressful, careful pediatric evaluation and perceptive observation of his adjustment assume additional importance. The social worker should know what factors in the birth history of a child are significant. She should get this information as accurately and thoroughly as possible, and make it available to the child's pediatrician both for pre-adoptive study and after adoptive placement. In addition to birth history it is important to learn as much as possible about the baby's condition at birth, his color and any delays or difficulties in his beginning to breathe. His adjustment in the hospital in the first few days of life should be known, particularly such factors as jaundice, excessive crying, and variations from a usual course of feeding or sleeping.

In placing children for adoption early, it is important to know as much as one can, to be aware of what cannot be known and to be guided by the considerations which are most compelling for the child's future well-being. His best hope of a happy future lies in acquiring adoptive parents who can adapt to his particular needs when he is very young. Knowledge about the child's family and about the beginning of his life will help in gaining understanding, not only of problems which he may have, but of his individual characteristics. At birth he is already different from every other baby, having had experiences which have helped to make him so. If we understand these differences we will be better able to provide him with the environment in which he can achieve his full potentialities.

[9] *Ibid.*

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NEWS FROM THE FIELD

Surplus Property Bill

REPRESENTATIVE Kenneth B. Keating of New York has proposed a bill in the House amending the Federal Property and Administrative Services Act of 1949, which grants surplus government property for research and other such purposes, to include "welfare or recreation agencies."

Eligible agencies are defined as tax-supported agencies which serve people in institutions and in groups and tax-exempt agencies which meet one of the following criteria: licensed by a state standard-setting agency; receive funds through a state or local community fund or similar federated fund-raising body; or are affiliated with, or part of, a national standard-setting organization.

The proposed bill would make available, free except for cost of care and handling, property no longer needed because of change or reduction of operation of a government agency, as follows:

Personal property: all property except real estate, naval vessels, and federal records; includes handtools, machine tools, desks, chairs, x-ray machines, vehicles, and many other types of movable and usable equipment and supplies.

Real property: land, land and buildings, or buildings only; includes government-owned land and government-owned buildings situated on land not belonging to the government.

The League was one of the national agencies which urged the introduction of this bill. Local agencies are encouraged to support this bill by writing to their local Congressman.

YOUTH IN OUR CHANGING CULTURE*

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The broad historical changes in the middle class, which the author believes typifies "American culture," are of deep concern because of their impact on youth. This is a new group which increasingly needs social services.

It is a difficult and complex world for all of us, but especially for those coming into maturity in change so rapid that there seems to be little that is sure or stable. Yet we tend to blame youth for their troubles which we have created or do not understand.

What is this "change"? It is, basically, related to our social evolution from an agricultural to an industrial economy, from an authoritarian to a democratic concept of authority, from a provincial to a national and increasingly international society, from stability to dynamic fluidity. The individual grows and forms in a greatly expanded world; personal contacts have become less important determinants than impersonal institutions. The family's functions are changing, the individual's roles are no longer predetermined and clear, new values come with new authorities, and a changed and more subtle psychological climate surrounds youth. Stability, surely a human need, is decreasingly provided by social structures and "externals," and has to be "built in," largely by the individual himself. This is so difficult without attendant information, skills and understanding, that it is not surprising that many people frantically seek "sureness" in the conformity of the group. It is our generation's task, in the institutions of family, church, education, community, to provide opportunities for this internal security essential in a dynamic age.

Our Changing Society

Many insist that the American family is degenerating, but it is more accurate to say that it is changing. We recognize various distinct types in our heritage, among them the New England Puritan, the Southern aristocrat, the Quaker, the Western pioneer. Further, there are many regional, environmental and class variations today.

Some say that in our generation there has been as much social movement as in all our previous history—and that "we haven't seen anything yet!" Changed tools and ways of life always bring changed social relationships, and change in any factor of a culture affects the total culture. It is pertinent, then, to ask what is happening, why, and with what results—and even what kind of great-grandparents we shall be.

The Changing Family

Social man has evolved from a rural agricultural or craft "subsistence economy" through an early "production economy of scarcity" to a later industrial "economy of consumption and abundance." The family has accordingly changed from a "patriarchal" to a "nuclear, conjugal, or companionship" unit. The early family, composed of many members, had the bond of land or craft, symbolized its perpetuity by the paternal name, and consciously preserved its stability—for instance, by arranged marriages. Today's family is smaller, more mobile, has a relatively unstable marriage bond, means less to the individual, and makes fewer demands on him. Social security—the care of orphans, the handicapped, the aged—which formerly lay entirely within the family, now rests in governmental, professional, and voluntary institutions.

The individual's "place" in the family is increasingly unclear. The former hierarchical authority pattern and clarity of leading and

* Given under the auspices of the National Association on Service to Unmarried Parents at National Conference of Social Work, Philadelphia, Pa., May 21, 1957.

supporting, usually determined by age and sex, have given way to vaguer "shared responsibility" and "democratic equality." We have to consider what "equality," or even a measure of equality, means in terms of age and sex roles to the growing child. It means that one need not "wait" to be allowed to do adult things. "Boy's work" has become "girl's work," and vice versa. Girls drive cars and cut grass, boys wash dishes and vacuum the rug. Young people think and act within greatly enlarged limits, some of them seeing no limits at all. Whether these expanded areas are seen as "privilege," "right," or "duty" is not the question.

We have, further, both "lengthened" and "shortened" childhood. Extended education postpones adult life to the late teens and early twenties, with relatively few boys and girls doing the work of adults at fifteen and sixteen. But children are encouraged in our families, schools, and communities to early autonomy. When is one a child and when a grown-up? More importantly, when is one a *man* or *woman*? At one time a girl put up her hair and a boy graduated to long trousers —the closest our culture has come to public "initiation rites." Today the driver's license, and perhaps the legal right to drink, are important personal milestones, but they relate more to what society *permits* than what it *expects* in terms of adult behavior. They lack, too, the public spotlight for a modern equivalent of formal induction into the adult councils of the village or tribe. Again, such milestones only recognize one as "old enough" but not as a man or woman. Boys and girls are delighted to be allowed to drive, but they often wish people would listen to their ideas, too. They *feel* responsible and adult, whether they fully are or not, and resent not being approached as such. If status is not clear, one has to prove status. Is there not a connection here with a great increase in drinking and smoking among adolescents? And much of this proof comes through sexual experience, for this is a short cut to adult manhood and womanhood. Those young people who most need to be recognized as adult, by themselves as well as by society, are almost certain to seek short cuts.

The older family system, where children shared the work world with their parents, sons aspired to be like their fathers and daughters like their mothers, has changed to one where children are expected to be different from, often better than their parents. Much of our "education" is dedicated to this aim. Clearly the early family generally afforded more emotional security than the family of today, if security is seen as the corollary of interdependence, insecurity of independence. But this type of family had to give way because it was geared to geographical and social stability, to static tradition, whereas modern life demands change and mobility. The cost of greater freedom and mobility is role diffusion beyond that of age and sex, involving career, class, and values. In this stage of social life, man seems to "miss" the clearly printed directions and seeks rather desperately to know himself. He has reached for freedom, but in achieving some measure of its attendant opportunity he has also found confusion. It is difficult not to *know* who you are—and to have to *make* one's self a reality.

Have we considered the psychological impact of our insistent question to young people—"What are you going to be?" A few astute young people are asking back, "What is life going to permit me to be?" They know that they have neither the certainty of no choice nor the freedom to make their own choices. Does the human being need role clarity? Possibly not, in the older terms of having things staked out for him at birth, but he does need "clues" of some kind.

Whatever change the family has experienced, some functions remain and are likely to persist. The family is a biological and economic living unit, primary in its emotional effect and in the formation and support of values. While many families today—the ones social welfare comes to know best—are failing in this fundamental responsibility, it seems that many others are succeeding as few early families could. They are consciously concentrating on the few functions inherent to healthy family life in any place or time. Found in all areas and classes of Amer-

ica today, they are nurturing children and youth of marvelous health and maturity. The parents believe in "family," but they also believe in their children's individual personalities and in the future. They help their children to attain the knowledge, experiences and attitudes needed in modern life—particularly personal skills and respect for others. These parents are themselves relatively secure. Their children confront the same complexities as others, but they have within themselves the ability to inquire, experiment, decide, and act with intelligence and humility. They have a sensitivity to people and to situations, based on strong and conscious principles. They have "values," but these are functional to the times.

New Authorities and Values

Value shifts always follow function shifts. According to David Riesman's descriptive character types, the tradition-directed would feel "shame" or "pride," the inner-directed "guilt" or "righteousness," the other-directed "anxiety" or "identity," as he responded to social interaction. In our increasingly other-directed society youth in particular do not value doing what the family expects or even what their consciences tell them as much as what their peers expect or what life demands. Much of one's life now takes place outside the home. A person's *worth* is measured by society in terms of his relationship to his enlarged world rather than to his family. In short, in terms of operation under new authorities, man "succeeds" or "fails."

Concepts of individual and social responsibility shift with the locus of authority. If, for instance, a young man's life is not wholly determined by his family, what is his responsibility to them? We can no longer clearly define an individual's responsibility to ill, handicapped or indigent relatives.

One young man, whose father is mentally ill, the mother's "work" necessarily the care of this "patient," is the oldest of four children. At one time he would have "sacrificed" for the family—but in a time and community where he would have had sustaining social supports. He is, actually, going to college to equip himself for a career in teaching or social work, feeling somewhat guilty about his family on relief, but more concerned about his future than about his responsibility to them. The boy's peers—the only community he has—constantly tell him to see to his own life and warn him against "ruining" himself for a family that is society's and not a son's concern.

The social supports of today, then, in terms of the success imperative so pointed in American culture, would sustain only a person's intelligence and courage pursuant to his own future.

There are, then, new authorities. Parents, religious leaders, even teachers, are increasingly secondary to the mandates of the current success imperative. Modern life gives most of us a terrifying and inconsistent combination of free choice and rigid patterns. An individual seems forced to take matters into his own hands but also seems caught in the intricate meshes of highly specified routes to this college or that job.

Youth is pushed to initial decision, but is heavily circumscribed by social controls that take over his destiny. These new authorities are "real" in their impact, but they are also vague and blurred. They are rarely individuals, such as a father or teacher, but "the gang," "the world of work," "what a fellow has to do to get ahead," in vast bureaucracies. Youth know that reality lies all around them, but they find it difficult to grasp, understand, or experience.

The "Last Leisure Class"

It is ironic that the more educators try to "make school real," equating it with life as against preparation for life, the more youth seem to be insulated from reality. They no longer share their parents' work worlds, and because their training is lengthened, formalized and institutionalized, few real concerns of daily living demand their thought and energy. Responsible and productive work is increasingly denied youth, whether related to "family chores" or to "work for money," and *this in a work-oriented society!* Children are, as Dorothy Barclay recently wrote,[1] "the last leisure class," often bored, some-

[1] "Jobs for the 'Last Leisure Class,'" *New York Times Magazine*, April 14, 1957.

times desperate in their search for rigorous and responsible activity. How many community centers *use* the creative imagination and organizing ability of youth?[2] It is no wonder teen-agers have created their own "never-never land" from which they exclude adults as they themselves have been excluded. We are inconsistent in our general training for responsibility and work competence and our denial of their use to those ready for them.

The concepts and structure of democracy, so precious to us, cause confusion because we have not really clarified the meaning of authority in a democracy, certainly not with respect to family, school, or community center, where immature citizens are being guided toward adult life. Authority resides in each person, even in each child, and is also "built" or "made" by the entire group. "Set rules" are not compatible to the democratic personality—unless there has been participation in forming them. Democratic youth feel this just as much as democratic adults, understanding pretty well that law in America may not have been made with their help but was nevertheless made democratically. Within institutions, however, adult-made rules handed out to youth, at one time compelling authorities, are increasingly useless—because they are not accepted.

Social history is a record of man's fight against exploitation, from governmental levels to the family, the refusal to permit unfair use of the human being. As exploitation has been routed, however, manipulation has taken its place. Manipulation is not new, but it has new dimensions in the democratic face value of letting others think they have made the decisions—the psychological mechanisms pertinent to persuasion. In a culture which values free choice this is a further frustration. In trying to understand youth, we should recognize both their search for autonomy and their frustrations in not finding it.

Today's Psychological Climate

This is the Age of Freud. Young people, nurtured on mass media, have discovered that everything is mother's fault. This was hard on mother until she learned she could blame it all on *her* mother. We have deepened understanding of the growth and development of the human being, of the interrelationship of physical, mental, and emotional "selves," but we do not know what this means in terms of moral or legal responsibility.[3] When is an individual "accountable" for his actions?

It is also an age in which many homes are "broken"—and some others ought to be. Untold numbers of families are "broken" psychologically, and as many as one out of four end in divorce. There is an increase of remarriage, on a statistical average, and this involves an increasing number of couples with children. Today at least one out of twenty-five American children under eighteen is seriously affected by divorce. Court decisions try to give first priority to the welfare of children, but to what extent can they succeed when they have to fix "legal blame" and when parents often use the children as tools of battle? A child will be "uprooted" by this experience, and we can only try to help him be the kind of person that can grow elsewhere.

Social mobility has many dimensions, and one of them is added by the automobile. "Get away from home" is the implication, and the automobile is increasingly attractive and available to youth. It is no longer just a tool of transportation but, increasingly, a status-conferring object, probably more important to the young people of today than the appearance of the home.

We follow the automobile naturally to the subject of sex. A European visitor concluded that ninety percent of sex in America takes place in cars—with drastic effects on attitudes toward sex. This may actually be true if we refer to the sex experiences of adolescent youth. Another visitor commented that no culture in the world so stimulates while it also condemns sex. This is true and illogical. There is no trend toward diminished stimulation—quite the reverse. Young people of

[2] EDITOR'S NOTE: See "Public Welfare in Wisconsin," Washington: Children's Bureau, 1957, pp. 9–18.

[3] Meyer Levin's *Compulsion* dramatically presents this problem.

today are caught firmly between what society at once encourages and disapproves.

The current vogue of "going steady"—"premarital monogamy," as President Cole of Amherst[4] puts it—is an effort to ride both horns of the dilemma. The morality of going steady may be a matter of "opinion," but there is increasing evidence that this practice robs youth of important varied interpersonal experience and that it encourages too-early marriage. Certainly earlier marriage is with us, and statistically these marriages have less survival value than later ones. Further, there is a great increase in premarital pregnancy—once a college problem, now a high school and junior high school concern.[5]

In the last ten years there has been a 400 percent increase in unwed mothers between fifteen and seventeen. One out of four is under eighteen. Even if their own mothers help them to keep their babies, American society does not permit these unwed girls such a solution without severe emotional cost to themselves and their children. The psychological trauma of the entire experience is not one easily dismissed—or eliminated even by skilled guidance.

One young man of eighteen sagely commented, "Society is nuts! They make you take driving courses so there won't be so many accidents, but they won't help you with your sex life. And sex means *real* trouble—not just a cracked-up car!" Another said, "Everyone says sex is natural and good—and it is—but then acts as if it is bad. Something's wrong somewhere."

We know "something is wrong," but have not even come to open and objective analysis and discussion.

Those of us who experienced the Depression find it difficult to understand the values of youth who have known nothing but relative plenty. What does our present economy of abundance mean as regards life values? Does it not mean that we have to shift from laws and attitudes tuned to locks, personal property, and scarcity to those that make it possible for all to enjoy comfortable lives? We are moving into a future of plenty, where "things" will really be cheap. Does this mean that we finally have conditions conducive to placing more value on human elements than material ones? Callous waste and destruction are costly and unintelligent, but youth may be more "moral" than adults in treating material possessions lightly. Possessions are not the "good life," but only among the various means to a good life. "Mom," I once heard a girl say, "the dress isn't important—*I* am."

Prosperity may be one of many factors contributing to the group nature of young people's activities. Many children don't have to do family chores or work after school, and can afford carfare, spending money, and all the appurtenances of being a member of a club, gang, or clique. Few have the experience of privacy. Most are unhappy alone, and escape into restless activity with others. This may mean they are happier but also that they are denied thought and creativity that come from aloneness. It is not that they cannot think and wonder, but that they do not permit themselves the time or opportunity to do so. They are no different from adults here, but late adolescence seems to be one of the most appropriate life spots for philosophic introspection—for self-discovery. Are we, in our guidance of youth, consciously providing opportunity for this experience?

We are pursuing knowledge of the individual—certainly not in self-knowledge—but most notably through tests of intelligence, achievement, personality, vocational preference, psychological aptitude, and so on. The human being becomes a pattern of holes punched in an I.B.M. card which, if routed to the correct channel by the right date, enables him to move on greased skids to this college or that job. Useful, yes, if tempered with wisdom, but dangerous and defeating in much actual practice—especially when it all takes place against the subject's will, without his understanding, and with little interpretation to him. There is a difference between the boy who discovers with joy that he has an aptitude for science and therefore enters the field with some security, and another who shrugs

[4] *Harper's Magazine*, March 1957.

[5] It was unofficially reported, for instance, that a large metropolitan junior high school had 240 pregnancies in one year.

his shoulders, saying, "If it shows I'm no good, I don't see any point in trying." It is perhaps worst of all for the great number who show no particular strengths—in an age which demands outstanding proficiency "if one is really going to get anywhere." Have we tried to understand the pressures on youth in our testing program?

Perhaps our age is one which spells the end of adventure. Young people feel hemmed in, having grown up with harnesses, play pens, enclosed back yards, walled school yards, supervised recreation, and standardized and homogenized education. Largely gone are the woods, meadows and streams for intensive free exploration; in their place have come "educational" and organized nature walks in the parks, trees and flowers neatly labeled. Rabbits are in the zoo, fish are in the home aquarium, horses are on television. A boy can't become absorbed in building a crystal radio set, for several sets in the house work far better. One can demonstrate the jet principle with a balloon or carbon dioxide capsule, but the real thing is too expensive and complicated for the children's world of discovery and invention. Adventure today means years of rigorous training and then a job in expensive subsidized laboratories. The average person is encouraged only to become an *operator* of things made and invented by others.

The Task of Social Welfare

Awareness of the social and emotional confusions is necessary to understand the problems of youth and their solutions. The lack of role clarity, the rootlessness of family and community life, the new and unclear authorities and values, the inconsistency of freedom and rigidity, the changing climate of psychological and social life make up our world. Many youth, defeated from the start, will continue to concern social workers. Many others at best will settle for the chromium-plated "pretty good life." In it they will know some comfort, security and success, but will not grapple with the concerns nor make the commitments that push social men into something better.

The most able youth, however, the best nourished, are already demonstrating a new maturity, to which most of us should bow in awed respect. They will raise their children with more understanding guidance, making the limits clearer; they will demonstrate more affection. They are already erasing the boundaries of race, religion and geography that have distorted our attitudes and actions. Understanding bureaucracies, they will work with them, through them, and beyond them. Knowing "education" is something better than they experienced, they will try to see that their children get it. There is so much to *know*, to *learn to do*, to come to *feel* and *understand*. It is probable they will push open new areas of adventure, not only in the nucleus of the atom or in cosmic space, but also in human society—which needs all the intelligence, precision and creative imagination man has. In hoping to do all this they cry to be permitted significant participation in home, community, and world.

As we work with the many already defeated boys and girls, let us not forget those with health and strength. Can social workers, along with others connected with youth, help more of our boys and girls to be in this healthy group? As young people are exposed to more people and situations outside the home—and therefore more difficult to understand or trust—can we make both a more challenging and trustworthy environment for their growth to supply the elements of trust, to permit more real freedom but also to give "clearer signs" and more protective devices. We need, in short, a scientific as well as a personal sensitivity to the *human* element of modern industrial society.

Social welfare, like medicine, should see more to prevention than to cure. This means more work with parents—do they know how to handle family finance, how do they use their leisure time, and in what ways do they nourish family togetherness? It means dealing with people and institutions affecting youth—how are children "treated" in schools, hospitals, community centers? It means working for the *conditions* of healthy living—in housing, medicine, recreation, and work. It particularly means helping to modernize and humanize "law," as in definitions of sex crime, in the purposes of a "reform school," or in the use of foster homes. Children belong to themselves, to all society, and to the future. We of the older generation need both to free and to guide them in this their great adventure.

BOOK NOTES

Self-support in Aid to Dependent Children: The California Experience, by Margaret Greenfield. Berkeley: University of California, Bureau of Public Administration, 1956. 156 pp. $2.00.

This comprehensive and engaging report, of the California program for helping adults in families receiving ADC become self-supporting, is important and timely.

The ADC program was originally intended to strengthen and maintain family life for needy children by enabling "the mother to stay at home and devote herself to housekeeping and the care of her children." In recent years public resentment has developed because now many of the families for whom ADC had originally been established are covered by Old-Age and Survivors Insurance benefits and because more women work instead of accepting assistance which would enable them to remain at home to care for their children. As a result the recipients of ADC in many states are largely unmarried mothers and their children, unskilled and other workers not eligible for Old-Age and Survivors benefits.

The 1951 California legislature reflected this changing attitude toward the program by enacting the self-support amendment which stated: "Children may be disqualified for assistance if their parents refuse to accept reasonable employment or vocational rehabilitative training." Other states also moved in this legislative direction.

In 1956, Congress amended Section 401 of the Social Security Act, effective July 1, 1957, to read

> "for the purpose of encouraging the care of dependent children in their own homes or in the homes of relatives by enabling each state to furnish financial assistance and other services, as far as practicable under the conditions in such state, to needy dependent children and the parents or relatives with whom they are living, to help maintain and strengthen family life and to help such parents or relatives to attain the maximum self-support and personal independence consistent with the maintenance of continuous parental care and protection. . . ."

The California experience reveals to all concerned with state planning the serious administrative problems with which they must grapple in carrying out the intent of this amendment.

Mrs. Greenfield's documented report is based on data drawn primarily from the files of the California Department of Social Welfare, the Regional Office of the Bureau of Public Assistance, and field reports and administrative reviews of a sampling of case records. She has made excellent use of case records to show the range of problems encountered in the practical application of a policy which tests the outer reaches of case-work skill. Arbitrary suspension of grants occurred without regard to availability or suitability of employment for the individual or the question of child care. The report leaves no doubt about the need to strengthen training programs for public assistance workers.

Chapter VII on state supervision is an exercise in public administration. The problems of securing prompt and proper local compliance with state regulations are carefully described as is the wide divergence from state policy. Short of legislative measures enabling the State Department of Social Welfare to enforce its supervisory authority, the Department attempted a partial solution through reorganization with what it considered good results. However, the inherent conflict of interests and loyalties of county welfare administrators who are county employes and not state employes remained. The steps outlined to overcome or lessen the conflict include a vigorous public information campaign, a system of local citizen advisory committees, and possible legislative clarification of the state's supervisory authority.

The burden which the self-support policy placed upon the state employment service and the bureau of vocational rehabilitation is also depicted. Both agencies were ill-equipped to cope with mass referrals. An impressive effort of inter-agency cooperation emerged. Findings of a pilot rehabilitation project related particularly to the aid to dependent children program furnish important guides for making rehabilitation of public assistance recipients more effective.

The report should receive the respectful attention of those engaged in applying the 1956 Social Security Act Amendments.

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Womanpower. by the National Manpower Council. New York: Columbia University Press, 1957, 371 pp. $5.00.

This volume is the sixth publication of the National Manpower Council. Its preface states it "is designed to contribute to a fuller understanding of the nation's manpower resources by illuminating the present role of women in the working population." It includes valuable recommendations and presents much useful information relative to this important problem. Part One consists of a "summary of recommendations" and a "statement by the National Manpower Council," and Part Two includes chapters by the Council staff.

The summary of recommendations in Part One begins:

"Women constitute not only an essential but also a distinctive part of our manpower resources. They are essential because without their presence in the labor force we could neither produce and distribute the goods nor provide the educational, health, and other social services which characterize American society. They constitute a distinctive manpower resource because the structure and the substance of the lives of most women are fundamentally determined by their functions as wives, mothers, and homemakers.

"A revolution in women's employment has occurred in the course of the present century. Today, one third of all the women in the United States, aged fourteen and over, are in the labor force in any month, and well over two fifths—some 28 million—work in the course of a year. Three out of every ten married women are now working, and nearly two out of every five mothers whose children are of school age are in the labor force."

A number of recommendations are offered for expanding the opportunities for effective development and utilization of womanpower. To increase further our knowledge in these areas, it is recommended that "universities, foundations and government encourage and support research dealing with the impact of the increased employment of women upon family life, the rearing of children and the self development of women; upon the process of occupational choice among both younger and older women; upon the prosperity of the economy and living standards; and upon the availability of volunteer workers for community service functions." It is also recommended that the Secretary of Labor initiate a study to determine maximum use which could be made of womanpower in event of a national emergency, and establish a commission to review the adequacy of existing federal and state laws which have a direct bearing on the employment of women in today's economy.

The chapters by the Council staff dealing with special phases of the womanpower problem provide valuable background data. They analyze the implications of trends in the employment of women by age, occupation, and industry, the education and training of girls and younger and older women, the behavior of women in the labor market, the extent to which increase in womanpower can alleviate shortages of highly trained personnel, and the role of work in women's lives.

The Statement of the Manpower Council indicates that one eighth of young wives whose children are not yet of school age are employed at least part of the time, and that about one fifth of the female labor force now consists of women with children between the ages of six and seventeen. These facts seem to the writer to have considerable significance to those primarily concerned with child welfare.

Although admittedly it did not come within the scope of this study, this reviewer is led to ask whether or not preschool-age children, school-age children, and youth are being neglected in the interest of increasing our national output and in the desire of wives to increase the family incomes. Are social problems being created by our advancing national and family economic standards? Are adequate child day care facilities being provided by voluntary organizations or governmental agencies? Even if they are adequate, can they properly take the place of the mother in the home? Is there a correlation between the increase in present-day juvenile delinquency and the increasing number of mothers in the labor force? Is it

possible that, as a consequence of overutilization of womanpower, the quality of the future labor force is being decreased? Much research and study are necessary before these questions can be answered. These should be undertaken soon so that social consequences along with economic considerations can be considered when we speak of the value of increased womanpower as a national resource.

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CLASSIFIED PERSONNEL OPENINGS

Classified personnel advertisements are inserted at the rate of 15 cents per word; boxed ads at $7.50 per inch; minimum insertion, $3.00. Deadline for acceptance or cancellation of ads is eighth of month preceding month of publication. Ads listing box numbers or otherwise not identifying the agency are accepted only when accompanied by statement that person currently holding the job knows ad is being placed.

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PSYCHIATRIC or MEDICAL SOCIAL WORKER for community clinic serving mentally retarded under age 21. Require Master's degree in social work with 2 years' supervised experience. Salary range $4800–$5700. Box 7, Pulaski Heights Station, Little Rock, Ark.

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LOS ANGELES—Openings for two caseworkers with graduate training in expanding family and child welfare agency—multiple services including marital counseling, unmarried parents, financial assistance, child placement in foster home care and group care, psychiatric consultation. Highly qualified supervision. Standard personnel practices. Opportunities for advancement. Salary $4572–$6384 depending on training and experience. Write: Rev. William J. Barry, Assistant Director, Catholic Welfare Bureau, 855 S. Figueroa St., Los Angeles 17, Calif.

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